Massachusetts Department of Public Health

Office of Emergency Medical Services

Ambulance Regulation Program

PLAN OF CORRECTION

Service Number	License Expiration Date	Insp.	**RESPONSE DUE BY:**

Service Name

VEHICLE INFORMATION (if Applicable)

Is this vehicle a(n)___Addition___Replacement___Renewal

License Plate Number_____ Ambulance Class_____ Vehicle Unit Id_____

Vehicle Identification Number

Page	**Citation**	**Providers Plan of Correction** (provide details of corrective action that satisfies reported deficiencies) (for page and citation number refer to inspection report form)	**Completion Date**

Licensee representative's signature	Title	Date

Send P.O.C. to: **Dept of Public Health - O.E.M.S Ambulance Regulation Program**

Page _____ of _____

2 Boylston Street, 3rd Floor, Boston, MA 02116
Tel. 617-753-7300, Fx: 617-753-7320

OEMS Form 500-63 (4/00))

Note: Services using online form, keep one copy for your records and send one copy to OEMS